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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265352	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Rehab and Healthcare Center	312 Solley Drive Ballwin, MO 63021

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25073 Based on observation, interview and record review, the facility failed to ensure five residents who required assistance with activities of daily living (ADLs, personal care) received showers in accordance with their needs and preferences (Residents #4, #5, #7, #11 and #2). The sample was 11. The census was 44. Review of the facility's Skin Monitoring: Comprehensive Shower Review Sheet, showed: -Perform a visual assessment of a resident's skin while giving them a shower; -Report any abnormal looking skin (as described below) to the charge nurse immediately; -Forward any problems to the Director of Nursing (DON) for review; -Use the form to show exact location and description of the abnormality, using the body chart: -Describe and graph all abnormalities by number; -A space designated for residents' name and date; -A numerical listing from 1 to 14 for examples of visual assessment; -Space designated for certified nurse aide (CNA) signature and date shower provided; -Space designated to show if resident needed toenails cut; -Space designated for charge nurse signature; -Space designated for charge nurse assessment; -Space designated for interventions; -Space designated to show if forwarded to DON and DON's signature with date. Review of the Resident Showers policy, dated 10/22/22, showed: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Purpose: A shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors; -Policy: Residents are offered a shower at a minimum of once weekly and given per resident request: Procedure: Assist the resident to the shower room and assist to bathe as needed; -Assist the resident with dressing as needed; -Dry and comb the resident's hair; -Report any broken skin, bruises, rashes, cut, skin discoloration or reddened areas to the Charge Nurse; -Update the resident's Care Plan as needed. Review of the shower schedule on 5/23/24, showed: -Showers/baths were assigned by room number and not resident preference; -A note at the bottom of the sheet read: do not alter or change without DON or Assistant Director of Nursing (ADON) approval; -The shower sheet did not direct staff to chart showers/baths had been given or where to put the completed shower sheets to show a shower/bath had been given. 1. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/3/24, showed: -Cognitively impaired; -Substantial/Maximal assistance needed for toileting and showering with the helper doing more than half the effort; -Dependent assistance for transfers with helper doing all of the effort; -Uses a wheelchair. Review of the resident's undated care plan, in use during the survey, showed: -Focus: Resident has an ADL self-care performance deficit; -Goal: Resident will maintain current level of function in ADL's through the review date; -Interventions: Bathing/showers, total assistance, dressing, total assistance, oral care, resident has his/her own teeth, personal hygiene/oral care, total assist, transfer, resident requires mechanical lift with two staff assistance for transfers; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The care plan did not address the resident's preference for what time or days the resident should receive a shower. Review of the shower schedule, showed the resident's shower days were Wednesday and Saturday on the day shift. Review of the resident's shower sheets on 5/23/24, showed: -On 4/10/24, resident received a bed bath; -On 4/20/24, resident received a bed bath; -On 4/27/24, resident refused a bed bath; -On 5/8/24, resident received a bed bath; -On 5/15/24, resident refused a bed bath; -No other shower sheets were provided by the facility. Observations on 5/21/24 at 6:40 A.M., 9:08 A.M., and 12:32 P.M., on 5/22/24 at 6:23 A.M., 8:40 A.M., and 2:10 P.M., and on 5/23/24 at 7:10 A.M., showed the resident lay in bed with a Gastrostomy (g-tube, a tube surgically inserted through the abdomen into the stomach to provide hydration, nutrition and medications) infusing a nutritional supplement. His/Her hair was greasy with white flakes scattered throughout. His/Her mouth and teeth were coated with a thick white substance. His/Her fingernails were long and dirty. He/She had a distinct foul body odor. 2. Review of Resident #5's quarterly MDS, dated [DATE], showed: -Cognitively impaired; -No rejection of care exhibited; -Functional abilities: Dependent on staff for: -Transfers; -Oral Hygiene; -Shower/bath; -Personal hygiene. Review of the resident's undated care plan, in use during the survey, showed: -Focus; Resident has an ADL self-care performance deficit; -Goal; Resident will maintain current level of function in ADL's through the review date; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions; Bathing/showers, total assistance, dressing, total assistance, oral care, and personal hygiene/oral care; -The care plan did not address the resident's preference of what time or days the resident should receive a shower. Review of the shower schedule, showed the resident should have shower/bath on Tuesdays and Fridays on the night shift. Review of the resident's shower sheets on 5/23/24, showed: -On 4/2/24, resident received a shower; -On 4/16/24, resident received a shower; -On 4/30/24, resident received a shower; -On 5/10/24, resident received a shower; -No other shower sheets were provided. Observations on 5/21/24 at 7:38 A.M., 12:24 P.M. and 2:00 P.M. and on 5/22/24 at 7:00 A.M., 12:15 P.M., and 2:15 P.M., showed the resident lay in bed. His/Her hair was long and greasy. He/She had very long dirty facial hair with bits of dried food. His/Her fingernails were long and dirty. He/She smelled of body odor. During an interview on 5/21/24 at 9:30 A.M., the resident was able to answer yes or no questions. When asked if he/she had been provided a shower in the past week, the resident said no. When asked if he/she had received a shower/bath in the past two weeks, the resident said no. When asked if the resident preferred his/her hair long and wanted long facial hair the resident said no. When asked if staff brushed his/her teeth and/or trim his/her fingernails the resident said no. 3. Review of Resident #7's admission MDS, dated [DATE], showed: -No speech -Cognitively impaired; -Refusal of care 4-6 days but not daily; -Substantial/Maximal assistance needed for transfers, oral hygiene, personal hygiene, toileting and showering with the helper doing more than half the effort. Review of the resident's care plan, in use during the survey, showed: -Focus: Resident has ADL self-care performance deficit; -Goal: Resident will maintain current level of function through the next review date; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions: Resident totally dependent on (X) staff for repositioning and turning in bed (Specify Frequency) and as necessary. The resident is totally dependent on (X) staff for transferring; -The care plan did not address any additional ADL needs including preferred days and times for bathing and personal hygiene. Review of the shower sheet schedule, showed the resident was scheduled to receive showers on Monday and Thursday on the day shift. Review of the resident's shower sheets on 5/23/24, showed: -On 4/8/24, resident received a bed bath. No nurse signed the shower sheet; -On 4/15/24, resident received a shower. No nurse signed the shower sheet; -On 4/18/24, resident received a bed bath; -On 4/24/24, resident received a shower; -On 5/2/24, resident received a bed bath. No nurse signed the shower sheet; -On 5/6/24, resident received a bed bath; -On 5/9/24, resident received a shower; -On 5/16/24, resident received a shower; -On 5/20/24, resident received a shower. Observations on 5/21/24 at 7:18 A.M., 11:28 A.M., and 2:10 P.M., and 5/22/24 at 6:20 A.M., 8:20 A.M., 9:49 A.M., and 12:10 P.M., and on 5/23/24 at 7:10 A.M., showed the resident lay in bed with tube feeing infusing. He/She was non-verbal and not interviewable. His/Her hair was greasy with white flakes scattered throughout. His/Her mouth and teeth were coated with a thick white substance. His/Her fingernails were long and dirty. He/She had a distinct foul body odor. 4. Review of Resident #11's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No rejection of care exhibited; -Required total assistance with transfers; -Required partial/moderate assistance for showers bathing and personal hygiene; -Required set up help with eating and oral hygiene. Review of the resident's undated care plan, in use during the survey, showed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus; Resident has an ADL self-care performance deficit. -Goal: Resident will maintain current level of function in ADL's through the review date. -Interventions: Bathing/showers, total assistance, transfers, totally dependent on two staff using mechanical lift; -The care plan did not address what time or days the resident preferred to receive a shower. Review of the shower schedule, showed the resident should have a shower/bath on Tuesdays and Fridays on the night shift. Review of the resident's shower sheets on 5/23/24, showed: -On 4/8/24, resident received a bed bath. Shower sheet not signed by nurse; -On 4/18/24, resident received a shower; -On 5/9/24, resident received a shower; -On 5/16/24, resident received a bed bath; -On 5/20/24. Resident received a bed bath; -No other shower sheets were provided. Observations on 5/22/24 at 9:38 A.M. and on 5/23/24 at 7:00 A.M., 12:15 P.M., and 2:15 P.M., the resident lay in bed. His/Her hair was long and greasy. He/She had very long dirty facial hair with bits of dried food. His/Her fingernails were long and dirty. He/She smelled of body odor. During an interview on 5/21/24 at 9:30 A.M., the resident said he often refused to take a shower. He/She preferred bed baths. During bed baths staff did not offer to assist him/her with brushing his/her teeth, washing his/her hair, shaving or trimming his/her fingernails. 5. Review of Resident #2's quarterly MDS, dated [DATE], showed: -An original entry date of 2/7/24; -Cognitively impaired; -No refusal of care; -Substantial/maximum assist with eating, toileting, shower/baths, transfers and positioning in bed. Review of the resident's progress notes, dated 5/14/24, showed he/she was sent to the hospital. The facility was unable to provide any shower sheet for the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/23 at 1:30 P.M., the DON said she was unable to produce any shower sheets for Resident #2. Shower sheets were the only documentation to show if staff provided a shower or bath. The shower sheets should be scanned into the resident's electronic medical record. Records were kept for [AGE] years. Showers were assigned by the resident's room number and not the resident's preferences. That was the system in place when she started working at the facility two months ago. Showers and baths should be based on the resident's preferences and not assigned just by their room numbers. The residents' care plans should identify what the residents' preferences were for bathing. The care plans should provide guidance to what is needed to be provided during a bath or shower. During an interview on 5/23/24 at 12:30 P.M., the Administrator said she expected for residents to receive showers per their scheduled day. Staff should shower the residents and document the showers on the shower sheets provided at the nurses station. The shower sheets should be scanned into the residents' electronic records. MO00235838 MO00235862 MO00236188

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25073 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 42 opportunities, 4 errors occurred, resulting in an 9.52% error rate (Residents #4 and #5). The census was 44. Review of the facility's Medication policy dated 10/24/22, showed: Procedure: Nursing Staff will keep in mind the seven rights of medication when administering medication: -The right medication; -The right amount; -The right resident; -The right time; -The right route; -Right indication; -Right outcome; -Additional considerations include: The Rule of 3. The Licensed Nurse administering medications will perform three checks comparing the physician's order, pharmacy label, and Medication Administration Record (MAR): -Compare the Licensed Practitioner's prescription/order with the MAR (first check); -Compare the Licensed Practitioner's order with the pharmacy label on the medication package (second check); -Compare the pharmacy label and MAR (third check); Documentation: -The time and dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment; -Recording will include the date, the time and the dosage of the medication or type of the treatment. 1. Review of Resident #5's medical record, showed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included post heart attack, high blood pressure, vitamin B12 deficiency, and major depression; -An order, dated 5/31/23, for chewable aspirin (blood thinner used to prevent blood clots) 81 milligrams (mg) once daily; -An order, dated 6/09/23, for multiple vitamin tablet (vitamin supplement) once daily. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/8/24, showed the resident: -Was cognitively impaired; -Dependent on staff for all Activities of Daily Living (ADL's, personal care). During a medication administration observation on 5/21/24 at 7:28 A.M., Certified Medication Technician (CMT) A: -Did not administer chewable aspirin 81 mg; -Did not administer a multivitamin. 2. Review of Resident #6's medical record, showed: -A quarterly MDS, dated [DATE], showed the resident was cognitively intact; -Diagnoses included high blood pressure and anxiety disorder; -An order, dated 2/6/24, for losartan potassium (treats high blood pressure) 50 mg one tablet once a day; -An order, dated 3/27/24, for metoprolol succinate extended release (treats high blood pressure) 50 mg 24-hour tablet once daily. During a medication administration observation on 5/21/24 at 7:30 A.M., CMT A: -Did not administer losartan potassium 50 mg; -Did not administer metoprolol succinate ER 50 mg. 3. During an interview on 5/22/24 at 9:30 A.M., the Director of Nursing (DON), said CMT A said she thought he/she had provided the medications. CMT A didn't realize he/she had overlooked the over the counter (OTC) medications. CMT A did not have an explanation why the other mediations were not provided. She expected medications to be given as ordered. MO00235838

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25073 Based on observation, interview and record review, the facility failed to maintain complete and accurately documented clinical records regarding pressure ulcers (injury to the skin and /or underlying tissue usually over a bony prominence, as a result of pressure or friction) for one of 11 sampled residents (Resident #2). The census was 44. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/8/24, showed the following: -admitted [DATE]; -Cognitively intact; -Able to make self-understood; -Rejection of care 1-3 days per week; -Dependent on staff for transfers, locomotion, personal hygiene and bathing; -admitted with one Stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister on his/her coccyx (tailbone)); -admitted with one Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). Review of the resident's undated care plan, showed the following: -Focus: Resident has pressure ulcer to right buttock and coccyx (tailbone). Will refuse to turn and reposition. Refuses treatments and bathing; -Goals included resident will have no further skin breakdown; -Interventions included complete treatments as ordered by physician. To be followed by wound clinic. Review of the resident's treatment administration record (TAR), dated for February, March, April and May of 2024, showed staff documented they provided treatment to the coccyx/buttock area. Review of the facility's wound reports dated, 2/8/24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes dated 2/8/4, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. Review of the facility's wound reports dated, 2/15/24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. Review of the resident's progress notes dated 2/15/24, showed the resident was seen by the wound physician. The physician's notes were not in the resident's medical record. Review of the facility's wound reports dated, 2/20/24, showed the resident was hospitalized . Review of the facility's wound reports dated, 2/27/24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. Review of the resident's progress notes dated 2/27/24, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. Review of the facility's wound reports dated, 3/6/24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. Review of the resident's progress notes dated 3/6/24, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. Review of the facility's wound reports dated, 3/13/24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. Review of the resident's progress notes dated 3/13/24, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. Review of the facility's wound reports dated, 3/20/24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. Review of the resident's progress notes dated 3/20/24, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. Review of the facility's wound reports dated, 3/27/24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. Review of the resident's progress notes dated 3/27/24, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. Review of the facility's wound reports dated, 4/3/24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. Review of the resident's progress notes dated 4/3/24, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's wound reports dated, 4/10/24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. Review of the resident's progress notes dated 4/10/24, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. Review of the facility's wound reports dated, 4/17/24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. Review of the resident's progress notes dated 4/17/24, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. Review of the facility's wound report dated, 4/24/24, showed the resident was in the hospital. Review of the facility's wound reports dated, 5/1//24, showed the resident listed on the wound report. The report included measurements, treatment orders and interventions. Review of the resident's progress notes dated 5/1/24, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. Review of Review of the facility's wound reports dated, 5/8/24, showed the resident listed on the wound report. The report included measurements, treatment and interventions. Review of the resident's progress notes dated 5/8/24, showed the resident had been seen by the wound physician. The physician's notes were not in the resident's medical record. Review of the resident's progress notes showed he/she was sent to the hospital for evaluation and treatment. The resident was not going to return to the facility. During an interview on 5/23/24 at 12:30 P.M., the Director of Nursing (DON) said the wound nurse was responsible for measuring the wounds along with the wound physician. (Pressure and non-pressure) on a weekly basis. The measurements should be put on the wound report and then transcribed to the resident's weekly skin condition report in each resident's individual chart. The physician notes should be sent to the facility and scanned into each resident's permanent medical record. The facility did not have a current wound nurse, the Assistant Director of Nursing (ADON) had been filling in for the wound nurse. The facility wound reports were not part of the resident's medical records. The facility had been going through management changes. The wound nurse was terminated recently and had not been replaced yet. She could not explain why the wound reports were completed but the information was not put in the medical record. She said all of the residents' records from support services should be in the resident's medical record and available for review.